STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on review of policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for one of six residents reviewed (Resident 1) and failed to ensure that residents were free from neglect caused by a failure to administer medications as ordered by the physician for three of six residents reviewed (Residents 2, 3, 4). Findings include: The facility's abuse policy, dated January 1, 2024, indicated that each resident had the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 21, 2024, indicated that the resident was severly cognitively impaired, required the extensive assistance of staff with all her care needs, had diagnoses that included dementia, and had an indwelling urinary catheter (tube inserted directly into the bladder to drain urine). Resident 1's care plan, dated July 17, 2023, indicated that the resident was at risk for skin breakdown, had pressure ulcers on her buttock, and was to receive proper and frequent peri-care. Facility investigation documents, dated May 20, 2024, revealed that Resident 1's daughter was in to visit on May 19, 2024, at breakfast and then returned to visit the resident at supper. When Resident 1's daughter left the faciity on [DATE], at supper time, the resident was positioned on her back with a purple-striped night gown on. Resident 1's daughter returned to the facility on [DATE], at breakfast at approximately 7:30 a.m., and she reported to staff that she believed that her mother had not received any care since she left the building the night before at supper time. The Director of Nursing came to the resident's room and observed that the resident's thigh had a six-inch indentation from the urinary catheter tubing, that the resident's heels were red and mushy (Stage 1 pressure ulcer), and that the resident had a quarter-size bruise to her outer arm that was noticed by staff prior to that time. A witness statement provided by Nurse Aide 1, dated May 20, 2024, indicated that he did have Resident 1 on his assignment for the night of May 19, 2024. He further stated that he emptied the resident's urinary catheter at around 4:20 a.m.; however, he did not provide care to her at that time. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility documentation indicated that the resident received care at approximately 11:07 p.m. on May 19, 2024, and then not again until 8:30 a.m. on May 20, 2024. Interview with Nurse Aides 2 and 3 on May 22, 2024, at 11:42 a.m. revealed that they work the daylight shift and that there have been many times that Resident 1 does not get turned and repositioned through the night. They stated that the resident's daughter visits the facility almost twice daily every day, and she takes note of how her mother is positioned when she leaves and when she returns the next day. They stated that the resident's daughter has complained many times regarding the lack of care her mother receives. Interview with the the Director of Nursing and Nursing Home Administrator on May 22, 2024, at 3:08 p.m. revealed that they conducted an investigation into Resident 1's daughter's allegations regarding the lack of care on May 19 into May 20, 2024, and they did not believe that there was any neglect. They stated that their night shift staff chart care once per shift and that it was permissible for the staff to chart at the start of their shift and then provide care later in the shift without charting care again. They confirmed that Resident 1 had a six-inch indentation in her leg from the indwelling catheter and that once the catheter tubing was repositioned the indentation went away. They further confirmed that the resident has not had indentations from her catheter tubing or mushy red heels on any night when care is provided and that she did have the indentation and mushy red heels on the night in question. A witness statement from Licensed Practical Nurse 1, dated May 11, 2024, revealed that she was in the North nurses' station getting report when she overheard Resident 2 verbalize concerns of not receiving her nighttime medications to Registered Nurse 2. Resident 2 stated that her roommate got hers. After the report Licensed Practical Nurse 1 checked the cart and all of the medication packs for p.m. administration were out and not overlooked. The computer showed that p.m. medications were checked off. Then Registered Nurse 2 walked towards the nurses' station and stated that Resident 3 and Resident 4 stated that they were still waiting for their night medications. Licensed Practical Nurse 1 then went to tell the supervisor. They looked for the back hall empty medication packets and they were not in the can provided. The supervisor then looked in the garbage can in the nurses' station and pulled a garbage bag out with crushed bags, empty medication cups, paper garbage, one empty medication packet, and a drinking cup used with the medication pass containing crushed medications. They then looked into the nurse aides' garbage bins and found all of the empty back hall medication packets for May 11, 2024, p.m. medication administration, random pills, pills that the residents would have received, and a medication cup with room [ROOM NUMBER]-D written on the outside, which contained various medications in applesauce. Resident 3 was the only resident that had Metoprolol (used alone or in combination with other medications to treat high blood pressure) remaining in the packet for her May 11, 2024, p.m. administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement from Registered Nurse 3, dated May 11, 2024, revealed that Licensed Practical Nurse 1 came to her and stated that Resident 2 stated that she did not receive her nighttime medications. Shortly after, both Resident 3 and Resident 4 also stated that they did not get their nighttime medications. They began searching in the garbage cans. In the North Hall medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with crushed white powder in it, but not all of the pill packets were there. Then they checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. They also found a whole medication cup full of crushed meds labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. Registered Nurse 3 contacted the Nursing Home Administrator after these findings. A quarterly MDS assessment for Resident 2, dated May 8, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included hypertension (high blood pressure), End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), diabetes, cerebral vascular accident (CVA - commonly known as a stroke), seizures, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and received dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 2, dated August 30, 2021, included an order for the resident to receive one three milligram (mg) tablet of Melatonin (a hormone that helps to regulate daily body rhythms) at bedtime, and one 10 mg tablet of Rosuvastatin (used to lower bad cholesterol levels and fats in the blood) at bedtime. Physician's orders for Resident 2, dated October 13, 2022, included an order for the resident to receive one 50 mg tablet of Trazodone (used to treat major depressive disorder) at bedtime. Physician's orders for Resident 2, dated June 1, 2023, included an order for the resident to receive one 0.25 mg tablet of Ronpinirole (treats symptoms of Parkinson's disease and restless legs syndrome) at bedtime. Physician's orders for Resident 2, dated August 2, 2023, included an order for the resident to receive two 200 mg capsules of Vaccinium macrocarpon (Cranberry - used as an herbal treatment for digestive disorders and urinary tract infections) twice a day. Physician's orders for Resident 2, dated May 2, 2024, included an order for the resident to receive one 30 mg tablet of Mirtazapine (an antidepressant used to treat major depressive disorder) at bedtime. The Medication Administration Record (MAR) for Resident 2, dated May 2024 revealed that Registered Nurse 4 signed that the Melatonin, Rosuvastatin, Trazodone, Roninirole, Cranberry, and Mirtazapine as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 2, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 2, dated May 12, 2024, revealed that on May 11, 2024, at approximately 11:00 p. m. Licensed Practical Nurse 1 came to this registered nurse and stated that the resident was stating that she did not get her nighttime medications. This registered nurse and Licensed Practical Nurse 1 both searched for the resident's pill packs to see if the medications were still in there. When the resident's pill packs were located, they were open, and they were empty. Shortly after, other residents also stated that they did not get their nighttime medications. While searching the garbage can in the North medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with a crushed white powder in it, but not all the pill packs were in there. Licensed Practical Nurse 1 then went and checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. Along with the pill packs were a whole medication cup full of crushed medications labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. An interview with Resident 2 completed by the Nursing Home Administrator on May 14, 2024, revealed that the nurse came in around 8:00 p.m. on Saturday, May 11, 2024, and gave her roommate her medications and did not give her medications. A quarterly MDS assessment for Resident 3, dated February 28, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Coronary Artery Disease (CAD - is a narrowing or blockage of the coronary arteries, which supply oxygen-rich blood to the heart), hypertension, diabetes, Atrial fibrillation (AFib - is an irregular and often very rapid heart rhythm), and pacemaker. Physician's orders for Resident 3, dated August 11, 2020, included an order for the resident to receive one 750 mg tablet of Levetiracetam (used alone or together with other medicines to help control certain types of seizures) two times a day. Physician's orders for Resident 3, dated September 6, 2021, included an order for the resident to receive one 100 mg tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) two times a day. The MAR for Resident 3, dated May 2024 revealed that Registered Nurse 4 signed that the Levetiracetam and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. However, a packet, dated May 11, 2024, that contained the 100 mg tablet of Metoprolol for the p.m. administration was found in the trash. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 3, completed by the Nursing Home Administrator on May 14, 2024, revealed that her and her sister had never seen the nurse on the 2:00 to 10:00 shift and that they did not get their medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 4, dated April 17, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included cancer, A-Fib, hypertension, hypothyroidism (a condition where the thyroid does not create and release enough thyroid hormone into the bloodstream), and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Physician's orders for Resident 4, dated July 18, 2023, include orders for the resident to receive one 10 mg tablet of Atorvastatin (used to lower cholesterol and triglycerides levels to help prevent heart disease), angina (chest pain) at bedtime, two 125 mg capsules of Divalproex (used to treat certain types of seizures) at bedtime, and one five mg tablet of Apixaban (used to prevent serious blood clots from forming due to a certain irregular heartbeat) two times a day. Physician's orders for Resident 4, dated December 4, 2023, included an order for the resident to receive one 25 mg tablet of Metoprolol two times a day, and staff was to hold the medication for a heart rate less than 55 beats per minute. The MAR for Resident 4, dated May 2024, revealed that Registered Nurse 4 signed that the Atorvastatin, Divalproex, Apixaban, and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 4 completed by the Nursing Home Administrator on May 14, 2024, revealed that she did not get her nighttime medications on May 11, 2024. There was no documented evidence that any of the residents listed above refused their medications or were too lethargic (a condition marked by drowsiness and an unusual lack of energy and mental alertness) or disoriented at the time to take their medications. Interview with the Nursing Home Administrator on May 22, 2024, at 2:20 p.m. confirmed that through her investigation she was able to determine that Residents 2, 3 and 4 did not receive their medications as ordered by the physician, and that Registered Nurse 4 signed them off as being administered. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(a)(j) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on review of Pennsylvania's Nursing Practice Act, job descriptions, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a registered nurse administered medications as ordered by the physician for three of six residents reviewed (Residents 2, 3, 4). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's registered nurse job description signed by Registered Nurse 4 on May 1, 2024, indicated that the registered nurse was to supervise the day-to-day nursing activities of the facility during the tour of duty. The supervision was to be in accordance with the current federal, state, and local standards, guidelines and regulations that govern the facility, and as may be required by the Director of Nursing, to ensure that the highest degree of quality care was maintained at all times. They were to monitor medication passes and treatment schedules and ensure that medications were being administered as ordered and that treatments were provided as scheduled. A witness statement from Licensed Practical Nurse 1, dated May 11, 2024, revealed that she was in the North nurses' station getting report when she overheard Resident 2 verbalize concerns of not receiving her nighttime medications to Registered Nurse 2. Resident 2 stated that her roommate got hers. After the report Licensed Practical Nurse 1 checked the cart, and all of the medication packs for p.m. administration were out and not overlooked. The computer showed that p.m. medications were checked off. Then Registered Nurse 2 walked towards the nurses' station and stated that Resident 3 and Resident 4 stated that they were still waiting for their night medications. Licensed Practical Nurse 1 then went to tell the supervisor. They looked for the back hall empty medication packets and they were not in the can provided. The supervisor then looked in the garbage can in the nurses' station and pulled a garbage bag out with crushed bags, empty medication cups, paper garbage, one empty medication packet, and a drinking cup used with the medication pass containing crushed medications. They then looked into the nurse aides' garbage bins and found all of the empty back hall medication packets for May 11, 2024, p.m. medication administration, random pills, pills that the residents would have received, and a medication cup with room [ROOM NUMBER]-D written on the outside, which contained various medications in applesauce. Resident 3 was the only resident that had Metoprolol (used alone or in combination with other medications to treat high blood pressure) remaining in the packet for her May 11, 2024, p.m. administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement from Registered Nurse 3, dated May 11, 2024, revealed that Licensed Practical Nurse 1 came to her and stated that Resident 2 stated that she did not receive her nighttime medications. Shortly after both Resident 3 and Resident 4 also stated that they did not get their nighttime medications. They began searching in the garbage cans. In the North Hall medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with crushed white powder in it, but not all of the pill packets were there. Then they checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. They also found a whole medication cup full of crushed meds labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. Registered Nurse 3 contacted the Nursing Home Administrator after these findings. A quarterly Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs) for Resident 2, dated May 8, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included hypertension (high blood pressure), End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), diabetes, cerebral vascular accident (CVA - commonly known as a stroke), seizures, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and received dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 2, dated August 30, 2021, included an order for the resident to receive one three milligram (mg) tablet of Melatonin (a hormone that helps to regulate daily body rhythms) at bedtime, and one 10 mg tablet of Rosuvastatin (used to lower bad cholesterol levels and fats in the blood) at bedtime. Physician's orders for Resident 2, dated October 13, 2022, included an order for the resident to receive one 50 mg tablet of Trazodone (used to treat major depressive disorder) at bedtime. Physician's orders for Resident 2, dated June 1, 2023, included an order for the resident to receive one 0.25 mg tablet of Ronpinirole (treats symptoms of Parkinson's disease and restless legs syndrome) at bedtime. Physician's orders for Resident 2, dated August 2, 2023, included an order for the resident to receive two 200 mg capsules of Vaccinium macrocarpon (Cranberry - used as an herbal treatment for digestive disorders and urinary tract infections) twice a day. Physician's orders for Resident 2, dated May 2, 2024, included an order for the resident to receive one 30 mg tablet of Mirtazapine (an antidepressant used to treat major depressive disorder) at bedtime. The Medication Administration Record (MAR) for Resident 2, dated May 2024, revealed that Registered Nurse 4 signed that the Melatonin, Rosuvastatin, Trazodone, Roninirole, Cranberry, and Mirtazapine as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 2, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 2, dated May 12, 2024, revealed that on May 11, 2024, at approximately 11:00 p. m. Licensed Practical Nurse 1 came to this registered nurse and stated that the resident was stating that she did not get her nighttime medications. This registered nurse and Licensed Practical Nurse 1 both searched for the resident's pill packs to see if the medications were still in there. When the resident's pill packs were located, they were torn open, and they were empty. Shortly after, other residents also stated that they did not get their nighttime medications. While searching the garbage can in the North medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with a crushed white powder in it, but not all the pill packs were in there. Licensed Practical Nurse 1 then went and checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. Along with the pill packs were a whole medication cup full of crushed medications labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3 pill pack that still had a Metoprolol tablet in it. An interview with Resident 2, completed by the Nursing Home Administrator on May 14, 2024, revealed that the nurse came in around 8:00 p.m. on Saturday May 11, 2024, and gave her roommate her medications and did not give her medications. A quarterly MDS assessment for Resident 3, dated February 28, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Coronary Artery Disease (CAD - is a narrowing or blockage of the coronary arteries, which supply oxygen-rich blood to the heart), hypertension, diabetes, Atrial fibrillation (AFib - is an irregular and often very rapid heart rhythm), and pacemaker. Physician's orders for Resident 3, dated August 11, 2020, included an order for the resident to receive one 750 mg tablet of Levetiracetam (used alone or together with other medicines to help control certain types of seizures) two times a day. Physician's orders for Resident 3, dated September 6, 2021, included an order for the resident to receive one 100 mg tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) two times a day. The MAR for Resident 3, dated May 2024, revealed that Registered Nurse 4 signed that the Levetiracetam and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. However, a packet, dated May 11, 2024, that contained the 100 mg tablet of Metoprolol for the p.m. administration was found in the trash. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 3, completed by the Nursing Home Administrator on May 14, 2024, revealed that her and her sister had never seen the nurse on the 2:00 p.m. to 10:00 p.m. shift and that they did not get their medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 4, dated April 17, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included cancer, A-Fib, hypertension, hypothyroidism (a condition where the thyroid does not create and release enough thyroid hormone into the bloodstream), and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Physician's orders for Resident 4, dated July 18, 2023, include orders for the resident to receive one 10 mg tablet of Atorvastatin (used to lower cholesterol and triglycerides levels to help prevent heart disease), angina (chest pain) at bedtime, two 125 mg capsules of Divalproex (used to treat certain types of seizures) at bedtime, and one five mg tablet of Apixaban (used to prevent serious blood clots from forming due to a certain irregular heartbeat) two times a day. Physician's orders for Resident 4, dated December 4, 2023, included an order for the resident to receive one 25 mg tablet of Metoprolol two times a day, and staff was to hold the medication for a heart rate less than 55 beats per minute. The MAR for Resident 4, dated May 2024, revealed that Registered Nurse 4 signed that the Atorvastatin, Divalproex, Apixaban, and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 4, completed by the Nursing Home Administrator on May 14, 2024, revealed that she did not get her nighttime medications on May 11, 2024. There was no documented evidence that any of the residents listed above refused their medications or were too lethargic (a condition marked by drowsiness and an unusual lack of energy and mental alertness) or disoriented at the time to take their medications. Interview with the Nursing Home Administrator on May 22, 2024, at 2:20 p.m. confirmed that through her investigation she was able to determine that Residents 2, 3 and 4 did not receive their medications as ordered by the physician, and that Registered Nurse 4 signed them off as being administered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on review of facility investigations and clinical records, as well as staff interviews, it was determined that the facility failed to administer medications as ordered by the physician for three of six residents reviewed (Residents 2, 3, 4). Findings include: A witness statement from Licensed Practical Nurse 1, dated May 11, 2024, revealed that she was in the North nurses' station getting report when she overheard Resident 2 verbalize concerns of not receiving her nighttime medications to Registered Nurse 2. Resident 2 stated that her roommate got hers. After the report Licensed Practical Nurse 1 checked the cart and all of the medication packs for p.m. administration were out and not overlooked. The computer showed that p.m. medications were checked off. Then Registered Nurse 2 walked towards the nurses' station and stated that Resident 3 and Resident 4 stated that they were still waiting for their night medications. Licensed Practical Nurse 1 then went to tell the supervisor. They looked for the back hall empty medication packets and they were not in the can provided. The supervisor then looked in the garbage can in the nurses' station and pulled a garbage bag out with crushed bags, empty medication cups, paper garbage, one empty medication packet, and a drinking cup used with the medication pass containing crushed medications. They then looked into the nurse aides' garbage bins and found all of the empty back hall medication packets for May 11, 2024, p.m. medication administration, random pills, pills that the residents would have received, and a medication cup with room [ROOM NUMBER]-D written on the outside, which contained various medications in applesauce. Resident 3 was the only resident that had Metoprolol (used alone or in combination with other medications to treat high blood pressure) remaining in the packet for her May 11, 2024, p.m. administration. A witness statement from Registered Nurse 3, dated May 11, 2024, revealed that Licensed Practical Nurse 1 came to her and stated that Resident 2 stated that she did not receive her nighttime medications. Shortly after, both Resident 3 and Resident 4 also stated that they did not get their nighttime medications. They began searching in the garbage cans. In the North Hall medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with crushed white powder in it, but not all of the pill packets were there. Then they checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. They also found a whole medication cup full of crushed meds labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. Registered Nurse 3 contacted the Nursing Home Administrator after these findings. A quarterly Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs) for Resident 2, dated May 8, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included hypertension (high blood pressure), End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), diabetes, cerebral vascular accident (CVA - commonly known as a stroke), seizures, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and received dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 2, dated August 30, 2021, included an order for the resident to receive one three milligram (mg) tablet of Melatonin (a hormone that helps to regulate daily body rhythms) at bedtime, and one 10 mg tablet of Rosuvastatin (used to lower bad cholesterol levels and fats in the blood) at bedtime. Physician's orders for Resident 2, dated October 13, 2022, included an order for the resident to receive one 50 mg tablet of Trazodone (used to treat major depressive disorder) at bedtime. Physician's orders for Resident 2, dated June 1, 2023, included an order for the resident to receive one 0.25 mg tablet of Ronpinirole (treats symptoms of Parkinson's disease and restless legs syndrome) at bedtime. Physician's orders for Resident 2, dated August 2, 2023, included an order for the resident to receive two 200 mg capsules of Vaccinium macrocarpon (Cranberry - used as an herbal treatment for digestive disorders and urinary tract infections) twice a day. Physician's orders for Resident 2, dated May 2, 2024, included an order for the resident to receive one 30 mg tablet of Mirtazapine (an antidepressant used to treat major depressive disorder) at bedtime. The Medication Administration Record (MAR) for Resident 2, dated May 2024, revealed that Registered Nurse 4 signed that the Melatonin, Rosuvastatin, Trazodone, Roninirole, Cranberry, and Mirtazapine as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 2, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. A nursing note for Resident 2, dated May 12, 2024, revealed that on May 11, 2024, at approximately 11:00 p. m. Licensed Practical Nurse 1 came to this registered nurse and stated that the resident was stating that she did not get her nighttime medications. This registered nurse and Licensed Practical Nurse 1 both searched for the resident's pill packs to see if the medications were still in there. When the resident's pill packs were located, they were open, and they were empty. Shortly after, other residents also stated that they did not get their nighttime medications. While searching the garbage can in the North medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with a crushed white powder in it, but not all the pill packs were in there. Licensed Practical Nurse 1 then went and checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. Along with the pill packs was a whole medication cup full of crushed medications labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. An interview with Resident 2, completed by the Nursing Home Administrator on May 14, 2024, revealed that the nurse came in around 8:00 p.m. on Saturday May 11, 2024, and gave her roommate her medications and did not give her medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 3, dated February 28, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Coronary Artery Disease (CAD - is a narrowing or blockage of the coronary arteries, which supply oxygen-rich blood to the heart), hypertension, diabetes, Atrial fibrillation (AFib - is an irregular and often very rapid heart rhythm), and pacemaker. Physician's orders for Resident 3, dated August 11, 2020, included an order for the resident to receive one 750 mg tablet of Levetiracetam (used alone or together with other medicines to help control certain types of seizures) two times a day. Physician's orders for Resident 3, dated September 6, 2021, included an order for the resident to receive one 100 mg tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) two times a day. The MAR for Resident 3, dated May 2024 revealed that Registered Nurse 4 signed that the Levetiracetam and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. However, a packet, dated May 11, 2024, that contained the 100 mg tablet of Metoprolol for the p.m. administration was found in the trash. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 3, completed by the Nursing Home Administrator on May 14, 2024, revealed that her and her sister had never seen the nurse on the 2:00 p.m. to 10:00 p.m. shift and that they did not get their medications. An annual MDS assessment for Resident 4, dated April 17, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included cancer, A-Fib, hypertension, hypothyroidism (a condition where the thyroid does not create and release enough thyroid hormone into the bloodstream), and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Physician's orders for Resident 4, dated July 18, 2023, include orders for the resident to receive one 10 mg tablet of Atorvastatin (used to lower cholesterol and triglycerides levels to help prevent heart disease), angina (chest pain) at bedtime, two 125 mg capsules of Divalproex (used to treat certain types of seizures) at bedtime, and one five mg tablet of Apixaban (used to prevent serious blood clots from forming due to a certain irregular heartbeat) two times a day. Physician's orders for Resident 4, dated December 4, 2023, included an order for the resident to receive one 25 mg tablet of Metoprolol two times a day, and staff was to hold the medication for a heart rate less than 55 beats per minute. The MAR for Resident 4, dated May 2024 revealed that Registered Nurse 4 signed that the Atorvastatin, Divalproex, Apixaban, and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 4 completed by the Nursing Home Administrator on May 14, 2024, revealed that she did not get her nighttime medications on May 11, 2024. There was no documented evidence that any of the residents listed above refused their medications or were too lethargic (a condition marked by drowsiness and an unusual lack of energy and mental alertness) or disoriented at the time to take their medications. Interview with the Nursing Home Administrator on May 22, 2024, at 2:20 p.m. confirmed that through her investigation she was able to determine that Residents 2, 3 and 4 did not receive their medications as ordered by the physician, and that Registered Nurse 4 signed them off as being administered. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for three of six residents reviewed (Residents 2, 3, 4). Findings include: A witness statement from Licensed Practical Nurse 1, dated May 11, 2024, revealed that she was in the North nurses' station getting report when she overheard Resident 2 verbalize concerns of not receiving her nighttime medications to Registered Nurse 2. Resident 2 stated that her roommate got hers. After the report Licensed Practical Nurse 1 checked the cart, and all of the medication packs for p.m. administration were out and not overlooked. The computer showed that p.m. medications were checked off. Then Registered Nurse 2 walked towards the nurses' station and stated that Resident 3 and Resident 4 stated that they were still waiting for their night medications. Licensed Practical Nurse 1 then went to tell the supervisor. They looked for the back hall empty medication packets, and they were not in the can provided. The supervisor then looked in the garbage can in the nurses' station and pulled a garbage bag out with crushed bags, empty medication cups, paper garbage, one empty medication packet, and a drinking cup used with the medication pass containing crushed medications. They then looked into the nurse aides' garbage bins and found all of the empty back hall medication packets for May 11, 2024, p.m. medication administration, random pills, pills that the residents would have received, and a medication cup with room [ROOM NUMBER]-D written on the outside, which contained various medications in applesauce. Resident 3 was the only resident that had Metoprolol (used alone or in combination with other medications to treat high blood pressure) remaining in the packet for her May 11, 2024, p.m. administration. A witness statement from Registered Nurse 3, dated May 11, 2024, revealed that Licensed Practical Nurse 1 came to her and stated that Resident 2 stated that she did not receive her nighttime medications. Shortly after, both Resident 3 and Resident 4 also stated that they did not get their nighttime medications. They began searching in the garbage cans. In the North Hall medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with crushed white powder in it, but not all of the pill packets were there. Then they checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. They also found a whole medication cup full of crushed meds labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. Registered Nurse 3 contacted the Nursing Home Administrator after these findings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) assessment (mandated assessments of a resident's abilities and care needs) for Resident 2, dated May 8, 2024, revealed that the resident was understood, could understand others, had a diagnosis which included hypertension (high blood pressure), End Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), diabetes, cerebral vascular accident (CVA - commonly known as a stroke), seizures, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and received dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Physician's orders for Resident 2, dated August 30, 2021, included an order for the resident to receive one three milligram (mg) tablet of Melatonin (a hormone that helps to regulate daily body rhythms) at bedtime, and one 10 mg tablet of Rosuvastatin (used to lower bad cholesterol levels and fats in the blood) at bedtime. Physician's orders for Resident 2, dated October 13, 2022, included an order for the resident to receive one 50 mg tablet of Trazodone (used to treat major depressive disorder) at bedtime. Physician's orders for Resident 2, dated June 1, 2023, included an order for the resident to receive one 0.25 mg tablet of Ronpinirole (treats symptoms of Parkinson's disease and restless legs syndrome) at bedtime. Physician's orders for Resident 2, dated August 2, 2023, included an order for the resident to receive two 200 mg capsules of Vaccinium macrocarpon (Cranberry - used as an herbal treatment for digestive disorders and urinary tract infections) twice a day. Physician's orders for Resident 2, dated May 2, 2024, included an order for the resident to receive one 30 mg tablet of Mirtazapine (an antidepressant used to treat major depressive disorder) at bedtime. The Medication Administration Record (MAR) for Resident 2, dated May 2024 revealed that Registered Nurse 4 signed that the Melatonin, Rosuvastatin, Trazodone, Roninirole, Cranberry, and Mirtazapine as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 2, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 2, dated May 12, 2024, revealed that on May 11, 2024, at approximately 11:00 p. m. Licensed Practical Nurse 1 came to this registered nurse and stated that the resident was stating that she did not get her nighttime medications. This registered nurse and Licensed Practical Nurse 1 both searched for the resident's pill packs to see if the medications were still in there. When the resident's pill packs were located, they were open, and they were empty. Shortly after, other residents also stated that they did not get their nighttime medications. While searching the garbage can in the North medication room, they located several whole pills scattered throughout the bag along with a few empty pill packs and a medication cup with a crushed white powder in it, but not all the pill packs were in there. Licensed Practical Nurse 1 then went and checked the garbage in the soiled utility room and discovered two more bags of garbage with pill packs in them. Along with the pill packs were a whole medication cup full of crushed medications labeled for room [ROOM NUMBER]-D, a few more scattered pills, and Resident 3's pill pack that still had a Metoprolol tablet in it. An interview with Resident 2, completed by the Nursing Home Administrator on May 14, 2024, revealed that the nurse came in around 8:00 p.m. on Saturday May 11, 2024, and gave her roommate her medications and did not give her medications. A quarterly MDS assessment for Resident 3, dated February 28, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included Coronary Artery Disease (CAD - is a narrowing or blockage of the coronary arteries, which supply oxygen-rich blood to the heart), hypertension, diabetes, Atrial fibrillation (AFib - is an irregular and often very rapid heart rhythm), and pacemaker. Physician's orders for Resident 3, dated August 11, 2020, included an order for the resident to receive one 750 mg tablet of Levetiracetam (used alone or together with other medicines to help control certain types of seizures) two times a day. Physician's orders for Resident 3, dated September 6, 2021, included an order for the resident to receive one 100 mg tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) two times a day. The MAR for Resident 3, dated May 2024, revealed that Registered Nurse 4 signed that the Levetiracetam and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. However, a packet, dated May 11, 2024, that contained the 100 mg tablet of Metoprolol for the p.m. administration was found in the trash. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 3, completed by the Nursing Home Administrator, on May 14, 2024, revealed that her and her sister had never seen the nurse on the 2:00 p.m. to 10:00 p.m. shift and that they did not get their medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395860	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loyalhanna Care Center	535 McFarland Road Latrobe, PA 15650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 4, dated April 17, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included cancer, A-Fib, hypertension, hypothyroidism (a condition where the thyroid does not create and release enough thyroid hormone into the bloodstream), and schizophrenia (a serious mental health condition that affects how people think, feel and behave). Physician's orders for Resident 4, dated July 18, 2023, included orders for the resident to receive one 10 mg tablet of Atorvastatin (used to lower cholesterol and triglycerides levels to help prevent heart disease), angina (chest pain) at bedtime, two 125 mg capsules of Divalproex (used to treat certain types of seizures) at bedtime, and one five mg tablet of Apixaban (used to prevent serious blood clots from forming due to a certain irregular heartbeat) two times a day. Physician's orders for Resident 4, dated December 4, 2023, included an order for the resident to receive one 25 mg tablet of Metoprolol two times a day, and staff was to hold the medication for a heart rate less than 55 beats per minute. The MAR for Resident 4, dated May 2024, revealed that Registered Nurse 4 signed that the Atorvastatin, Divalproex, Apixaban, and Metoprolol as being administered at 9:00 p.m. on May 11, 2024. A nursing note for Resident 3, dated May 11, 2024, revealed that the physician was informed of the resident reporting about not receiving her nighttime medications. No new orders were received at this time. An interview with Resident 4 completed by the Nursing Home Administrator on May 14, 2024, revealed that she did not get her nighttime medications on May 11, 2024. There was no documented evidence that any of the residents listed above refused their medications or were too lethargic (a condition marked by drowsiness and an unusual lack of energy and mental alertness) or disoriented at the time to take their medications. Interview with the Nursing Home Administrator on May 22, 2024, at 2:20 p.m. confirmed that through her investigation she was able to determine that Residents 2, 3 and 4 did not receive their medications as ordered by the physician, and that Registered Nurse 4 signed them off as being administered. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.